Standard Bene	fit Plan Designs - FINAL				
	enefits and Coverage	Individual 8	& SHOP	Individual & SHOP	
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Platinum Coinsurance Plan		Platinum Copay Plan	
3/15/2013					
Actuarial Value - F	inal AV Calculator	88.19	%	88.0%	6
Overall deductible		\$0		\$0	
	for specific services	Ψ		Ψ	
	Medical	\$0		\$0	
	Brand Drugs	\$0		\$0	
	Dental	See attacl	hment	See attach	nment
Out-of-pocket lim	it on expenses	\$4,00	0	\$4,00	0
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)	\$20		\$20	
office or clinic	Specialist visit	\$40		\$40	
	Other practitioner office visit	\$20		\$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$20		\$20	
Tests	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat	Generic drugs	\$5		\$5	
illness or	Preferred brand drugs	\$15		\$15	
condition	Non-preferred brand drugs	\$25		\$25	
	Specialty drugs	10%		10%	
Outpatient	Facility fee (e.g., ASC)	10%		\$250	
surgery	Physician/surgeon fees	10%		C450	
	Emergency room services (waived if admitted) Emergency medical transportation	\$150 \$150		\$150 \$150	
Need immediate attention	Urgent care	\$40		\$40	
Haraite I. d	Facility fee (e.g., hospital room)	10%		\$250 per day up	
Hospital stay	Physician/surgeon fee	10%		to 5 days	
	Mental/Behavioral health outpatient services	\$20		\$20	
Mental health, behavioral health,	Mental/Behavioral health inpatient services	10%		\$250 per day up to 5 days	
or substance	Substance use disorder outpatient services	\$20		\$20	
abuse needs	Substance use disorder inpatient services	10%		\$250 per day up to 5 days	
	Prenatal care and preconception visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital	10%		\$250 per day up	

Notes:

Help recovering

or other special

health needs

Child needs

dental or eye care

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

Dental check-up - Preventive and Diagnostic

Dental Restorative and Orthodontia Services

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

Professional

10%

10%

\$20

\$20

10%

10%

No cost share

0%

1 pair per year

Plan Design, Note 6 Below

to 5 days

\$20

\$20

\$20

\$150 per day up

to 5 days

10%

No cost share

0%

1 pair per year

Plan Design, Note 6 Below

See Pediatric Dental Standard See Pediatric Dental Standard

- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:

services

Home health care

Rehabilitation services

Habilitation services

Skilled nursing care

Dental Basic Services

Hospice service

Glasses

Durable medical equipment

Eye exam (deductible waived)

http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

Standard Bene	fit Plan Designs - FINAL					
Summary of Be	enefits and Coverage		Individual 8	& SHOP	Individual & SHOP	
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Gold Coinsurance Plan		Gold Copay Plan		
3/15/2013						
Actuarial Value - F	inal AV Calculator		78.29	%	78.0%	6
Overall deductible			Φ0		\$0	
	for specific services		\$0		\$0	
Other deductibles	Medical		\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental Drugs		See attac	hment	See attach	nment
Out-of-pocket lim			\$6,40		\$6,40	
out of pooket iiii	it on expenses		ψ0, 10	,,,	φο, το	
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Typ	е	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an inj footnote)	ury or illness (see	\$30		\$30	
office or clinic	Specialist visit		\$50		\$50	
	Other practitioner office visit		\$30		\$30	
	Preventive care/ screening/ imr	munization	No cost share		No cost share	
	Laboratory Tests		\$30		\$30	
Tests	X-rays and Diagnostic Imaging		\$50		\$50	
	Imaging (CT/PET scans, MRIs)		20%		\$250	
Drugs to treat	Generic drugs		\$20		\$20	
illness or	Preferred brand drugs		\$50		\$50	
condition	Non-preferred brand drugs		\$70		\$70	
Condition	Specialty drugs		20%		20%	
Outpatient	Facility fee (e.g., ASC)		20%		\$600	
surgery	Physician/surgeon fees		20%			
	Emergency room services (wai		\$250		\$250	
	Emergency medical transportat	tion	\$250		\$250	
Need immediate attention	Urgent care		\$60		\$60	
Hacnital stay	Facility fee (e.g., hospital room)	20%		\$600 per day up	
Hospital stay	Physician/surgeon fee		20%		to 5 days	
	Mental/Behavioral health outpa	tient services	\$30		\$30	
Mental health, behavioral health,	Mental/Behavioral health inpati	ent services	20%		\$600 per day up to 5 days	
or substance	Substance use disorder outpati	ient services	\$30		\$30	
abuse needs	Substance use disorder inpatie	nt services	20%		\$600 per day up to 5 days	
	Prenatal care and preconception	on visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up	
	services	Professional	20%		to 5 days	
	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		000/		A a a	

Notes:

Help recovering

or other special

health needs

Child needs

dental or eye care

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

Dental check-up - Preventive and Diagnostic

Dental Restorative and Orthodontia Services

- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.

20%

\$30

\$30

20%

20%

No cost share

0%

1 pair per year

Plan Design, Note 6 Below

\$30

\$30

\$30

\$300 per day up

to 5 days

20%

No cost share

0%

1 pair per year

Plan Design, Note 6 Below

See Pediatric Dental Standard See Pediatric Dental Standard

- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:

Home health care

Rehabilitation services

Habilitation services

Skilled nursing care

Dental Basic Services

Hospice service

Glasses

Durable medical equipment

Eye exam (deductible waived)

http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

Summary of Benefits and Coverage	Individual	Individual
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan	Silver Copay Plan
3/15/2013		
Actuarial Value - Final AV Calculator	68.7%	68.3%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	\$2,000	\$2,000
Brand Drugs	\$250	\$250
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Typ	ре	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an ir footnote)	ijury or illness (see	\$45		\$45	
office or clinic	Specialist visit		\$65		\$65	
	Other practitioner office visit		\$45		\$45	
	Preventive care/ screening/ im	munization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
Tests	X-rays and Diagnostic Imaging	1	\$65		\$65	
	Imaging (CT/PET scans, MRIs		20%	Х	\$250	
	Generic drugs	,	\$25		\$25	
Drugs to treat	Preferred brand drugs		\$50	Х	\$50	Х
illness or	Non-preferred brand drugs		\$70	Х	\$70	X
condition	Specialty drugs		20%	Х	20%	Х
Outpatient	Facility fee (e.g., ASC)		20%	X	20%	X
surgery	Physician/surgeon fees		20%		20%	
	Emergency room services (wa	ived if admitted)	\$250	X	\$250	X
	Emergency medical transporta		\$250	X	\$250	X
Need immediate attention	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g., hospital room	n)	20%	X	20%	Х
1105pital stay	Physician/surgeon fee		20%		2070	^
	Mental/Behavioral health outpa	atient services	\$45		\$45	
Mental health, behavioral health,	Mental/Behavioral health inpat	ient services	20%	Х	20%	Х
or substance	Substance use disorder outpa	tient services	\$45		\$45	
abuse needs	Substance use disorder inpation	ent services	20%	Х	20%	Х
	Prenatal care and preconcepti	on visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%	X	200/	Х
	services	Professional	20%		20%	^
	Home health care	·	20%		\$45	
	Rehabilitation services		\$45		\$45	
Help recovering	Habilitation services		\$45		\$45	
or other special health needs	Skilled nursing care		20%	Х	20%	Х
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
	Glasses		1 pair per year		1 pair per year	
Child needs	Dental check-up - Preventive a	and Diagnostic				
dental or eye care	Dental Basic Services				See Pediatric De	
	Dental Restorative and Orthod	Iontia Services	Plan Design, No	ote o Relow	Plan Design, No	DIE P REIOM

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

Summary of Benefits and Coverage	SHOP	SHOP
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan	Silver Copay Plan
3/15/2013		
Actuarial Value - Final AV Calculator	69.8%	69.3%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	\$1,500	\$1,500
Brand Drugs	\$500	\$500
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

N 11 1						
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Ty	ое	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an ir footnote)	ijury or illness (see	\$45		\$45	
office or clinic	Specialist visit		\$65		\$65	
	Other practitioner office visit		\$45		\$45	
	Preventive care/ screening/ im	munization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
Tests	X-rays and Diagnostic Imaging		\$65		\$65	
	Imaging (CT/PET scans, MRIs	5)	20%	X	\$250	
D	Generic drugs		\$25		\$25	
Drugs to treat	Preferred brand drugs		\$50	Х	\$50	Х
illness or	Non-preferred brand drugs		\$70	X	\$70	Х
condition	Specialty drugs		20%	Х	20%	Х
Outpatient	Facility fee (e.g., ASC)		20%	Х	20%	Х
surgery	Physician/surgeon fees		20%		20%	
J. J.	Emergency room services (wa	ived if admitted)	\$250	Х	\$250	Х
	Emergency medical transporta		\$250	Х	\$250	Х
Need immediate attention	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g., hospital roon	า)	20%	X	20%	Х
1105pital Stay	Physician/surgeon fee		20%		20 /0	^
	Mental/Behavioral health outp	atient services	\$45		\$45	
Mental health, behavioral health,	Mental/Behavioral health inpa	tient services	20%	Х	20%	X
or substance	Substance use disorder outpa	tient services	\$45		\$45	
abuse needs	Substance use disorder inpati	ent services	20%	Х	20%	Х
	Prenatal care and preconcept	on visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х	20%	Х
	services	Professional	20%		20%	^
	Home health care		20%		\$45	
	Rehabilitation services		\$45		\$45	
Help recovering	Habilitation services		\$45		\$45	
or other special health needs	Skilled nursing care		20%	Х	20%	Х
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived		0%		0%	
	Glasses		1 pair per year		1 pair per year	
Child needs	Dental check-up - Preventive	and Diagnostic				
dental or eye care	Dental Basic Services	g			See Pediatric De	
	Dental Restorative and Orthod	Iontia Services	Plan Design, No	ote 6 Below	Plan Design, No	ote 6 Below

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

Summary of Benefits and Coverage	Individual & SHOP
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver HSA Plan
3/15/2013	
Actuarial Value - Final AV Calculator	71.5%
Overall deductible	\$1500 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See attachment
Out-of-pocket limit on expenses	\$6,400

Common Medical Event	Service Typ	٩	Member Cost Share	Deductible Applies	
LVCIIC	Service Typ	G	Onare	Applies	
Visit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)		20%	Х	
office or clinic	Specialist visit	20%	Х		
	Other practitioner office visit	20%	Х		
	Preventive care/ screening/ imr	nunization	No cost share		
	Laboratory Tests		20%	X	
Tests	X-rays and Diagnostic Imaging		20%	X	
	Imaging (CT/PET scans, MRIs)		20%	X	
Drugs to treat	Generic drugs		20%	X	
illness or	Preferred brand drugs		20%	X	
condition	Non-preferred brand drugs		20%	X	
	Specialty drugs		20% 20%	X	
Outpatient		acility fee (e.g., ASC)			
surgery	Physician/surgeon fees		20%	X	
	Emergency room services (wai		20%	X	
Nie z diboone die Ge	Emergency medical transportat	ion	20%	Х	
Need immediate attention	Urgent care		20%	Х	
Hannital atom	Facility fee (e.g., hospital room)		20%	Х	
Hospital stay	Physician/surgeon fee		20%	X	
	Mental/Behavioral health outpa	tient services	20%	X	
Mental health, behavioral health,	Mental/Behavioral health inpati	ent services	20%	Х	
or substance	Substance use disorder outpati	ent services	20%	X	
abuse needs	Substance use disorder inpatie	nt services	20%	Х	
	Prenatal care and preconception	n visits	No cost share	X	
Pregnancy	Delivery and all inpatient	Hospital	20%	X	
	services	Professional	20%	X	
	Home health care		20%	X	
	Rehabilitation services		20%	X	
Help recovering	Habilitation services		20%	X	
or other special health needs	Skilled nursing care		20%	Х	
	Durable medical equipment		20%	X	
	Hospice service		No cost share	X	
	Eye exam (deductible waived)		0%		
Child needs	Glasses		1 pair per year		
dental or eye care	Dental Basic Services		See Pediatric Dental Standard Plan Design, Note 6 Below		
	Dental Restorative and Orthodo	ontia Services	3 , 11111 5 2 11611		

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

Otandard Benefit Flair Besigns - Flitte					
Summary of Benefits	and Coverage	Individual 8	Individual & SHOP		& SHOP
COST SHARING AMOU ENROLLEE'S OUT O		Bronze Plan		Bronze HSA Plan	
3/15/2013					
Actuarial Value - Final AV Calculator		60.4%		59.0%	
Overall deductible		\$5000 integrated Med/Rx Ded		\$4500 integrated Med/Rx Ded	
Other deductibles for spe	cific services				
Medica	al	N/A	N/A		
Brand	Drugs	N/A		N/A	
Dental		See attacl	hment	See attachment	
Out-of-pocket limit on expenses		\$6,400		\$6,400	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies

Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Ty _l	oe	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an ir footnote)	ijury or illness (see	\$60	After 1st 3 non- preventive visits	40%	Х
office or clinic	Specialist visit		\$70	X	40%	X
	Other practitioner office visit		\$60	Х	40%	Х
	Preventive care/ screening/ im	munization	No cost share		No cost share	
	Laboratory Tests		30%	Х	40%	X
Tests	X-rays and Diagnostic Imaging)	30%	X	40%	X
	Imaging (CT/PET scans, MRIs	3)	30%	X	40%	Х
Duves to treet	Generic drugs		\$25	X	40%	X
Drugs to treat illness or	Preferred brand drugs		\$50	X	40%	X
condition	Non-preferred brand drugs		\$75	X	40%	X
condition	Specialty drugs		30%	Х	40%	X
Outpatient	Facility fee (e.g., ASC)		30%	X	40%	X
surgery	Physician/surgeon fees		30%	X	40%	Х
	Emergency room services (wa	ived if admitted)	\$300	X	40%	X
	Emergency medical transporta	ntion	\$300	Х	40%	Х
Need immediate attention	Urgent care		\$120	After 1st 3 non- preventive visits	40%	X
Hospital stay	Facility fee (e.g., hospital roon	۱)	30%	X	40%	X
1105pital Stay	Physician/surgeon fee		30%	Х	40%	X
	Mental/Behavioral health outpa	atient services	\$60	X	40%	X
Mental health, behavioral health,	Mental/Behavioral health inpat	ient services	30%	Х	40%	Х
or substance	Substance use disorder outpa	tient services	\$60	X	40%	X
abuse needs	Substance use disorder inpation	ent services	30%	Х	40%	Х
	Prenatal care and preconcepti	on visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	30%	X	40%	X
	services	Professional	30%	Х	40%	X
	Home health care		30%	X	40%	X
	Rehabilitation services		30%	Х	40%	Х
Help recovering	Habilitation services		30%	X	40%	Χ
or other special health needs	Skilled nursing care		30%	Х	40%	Х
	Durable medical equipment		30%	Х	40%	Х
	Hospice service		No cost share	Х	No cost share	Х
	Eye exam (deductible waived)		0%		0%	
01-11-1	Glasses		1 pair per year		1 pair per year	
Child needs	Dental check-up - Preventive a	and Diagnostic				
dental or eye care	Dental Basic Services				See Pediatric De	
	Dental Restorative and Orthod	Iontia Services	Plan Design, No	ore o pelom	Plan Design, No	DIE & REIOM

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:

Summary of Benefits and Coverage	Individual
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Catastrophic Plan
3/15/2013	
Actuarial Value - Final AV Calculator	60.4%
Organia de deseglido	(CAAAA - 1/D D1
Overall deductible	\$6400 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See attachment
Out-of-pocket limit on expenses	\$6,400

Common Medical			Member Cost	Deductible	
Event	Service Type	е	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)		0%	After 1st 3 non- preventive visits	
office or clinic	Specialist visit	0%	Х		
	Other practitioner office visit		0%	X	
	Preventive care/ screening/ imm	nunization	No cost share		
_	Laboratory Tests		0%	X	
Tests	X-rays and Diagnostic Imaging		0%	X	
	Imaging (CT/PET scans, MRIs)		0%	X	
Drugs to treat	Generic drugs Preferred brand drugs		0% 0%	X	
illness or	Non-preferred brand drugs		0%	X	
condition	Specialty drugs		0%	X	
Outpatient	Facility fee (e.g., ASC)		0%	X	
surgery	Physician/surgeon fees		0%	X	
J	Emergency room services (wai	ved if admitted)	0%	X	
	Emergency medical transportat	0%	X		
Need immediate attention	Urgent care		0%	After 1st 3 non- preventive visits	
Hospital stay	Facility fee (e.g., hospital room)		0%	Х	
1105pital Stay	Physician/surgeon fee		0%	X	
	Mental/Behavioral health outpa	tient services	0%	Х	
Mental health, behavioral health,	Mental/Behavioral health inpation	ent services	0%	Х	
or substance	Substance use disorder outpatient services		0%	X	
abuse needs	Substance use disorder inpatie	0%	Х		
	Prenatal care and preconception	n visits	No cost share		
Pregnancy	Delivery and all inpatient	Hospital	0%	Х	
	services	Professional	0%	X	
	Home health care		0%	X	
Halm was asserting	Rehabilitation services		0%	X	
Help recovering	Habilitation services		0%	Х	
or other special health needs	Skilled nursing care		0%	Х	
	Durable medical equipment		0%	Х	
	Hospice service		No cost share	X	
	Eye exam (deductible waived)		0%		
Child needs	Glasses Pontal chack up Proventive or	nd Dingpostic	1 pair per year		
dental or eye care	Dental check-up - Preventive and Dental Basic Services		See Pediatric Dental Standard Plan Design, Note 6 Below		
	Dental Restorative and Orthodo	ontia Services	9 /		

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf